JUL - SEP 1999

VOL 2 NO 3

NAVAL MEDICAL SURVEILLANCE REPORT

N M S R

Table of Contents

Data in the NMSR are provisional, based on reports and other sources of data available to the Navy Environmental Health Center. Notifiable conditions are classified by date of report. Only cases submitted as confirmed are included.

NAVAL DISEASE REPORTING SYSTEM (NDRS)

NDRS Evaluation

The Navy Disease Reporting System (NDRS) represents a paradigm shift in disease surveillance, involving changes in reportable events, reference populations, periodicity, and methods. We surveyed our NDRS users in 1998 to obtain feedback on the progress of this effort. A questionnaire was mailed to all possibly interested parties, and follow-up telephone calls to our major users resulted in the receipt of 59 responses. This represents all primary and secondary users (NEPMUs, major medical centers and branch clinics) but may not represent potential users on smaller vessels, which only rarely have reportable events. The survey represents the Naval Medical Centers, 11 Hospitals, all 4 NEPMUs, 7 branch medical clinics, and 17 vessel MTFs of all major class (except submarine). The respondents' age ranged from 20 to 52 years with a mean of 33. They were 80% male, 20% female, ranging in rank from E-3 to O-4 (with the majority from E-4 to E-7). All, except a very few, had used the NDRS in 1997 and 1998. We believe these responses represent the primary and secondary NDRS users.

The questionnaire consisted of demographic data, questions about computer capabilities at their workstation, 17 Likert-style response items of attitudes towards the program, and a final section to measure consensus on benefits and functions of the software.

The specific attitudinal questions analyzed were: #1) The NDRS is very easy to use; #2) The NDRS is a much better way to report disease than the old DARs system; #5) I use this program regularly to prepare reports for use by personnel at my own command; #6) I frequently use the program to answer questions about communicable diseases; #8) I use the program regularly to report communicable disease to the Health Department; #9) I could really use some training on this program; and #10) If I had my way, I would pitch this new program out the window (Questions 3, 4, and 7 were reinforcers and not analyzed separately).

Each Likert-style item had a statement followed by a scale of agreement from "Strongly agree" to "Strongly disagree." These choices were scored from 5 to 1 such that a higher overall score represented a stronger endorsement of NDRS. A few items were worded and scored in the opposite direction to enhance reliability. For example, the statement "The NDRS is very easy to use" was scored 5 for strong agreement, 1 for strong disagreement; and "If I had my way, I would pitch this new program out the window" was scored 1 for strong agreement, 5 for strong disagreement. Figure 1 shows the mean response to selected items by rank. The specific statements are given above. The users find the program easy to use and a much better way of reporting than the old DARS system. They do not use it much for local analysis or reporting to Health Department, feel a strong need for training, and do not want to "pitch it out the window."

Executive Editor
CDR R. W. Rendin, MSC, USN

Managing Editor
CDR B. P. Murphy, MSC, USN

Editors
R. C. Morrow, MD, MPH
LCDR S. B. Gombeh-Alie, MC, USNR

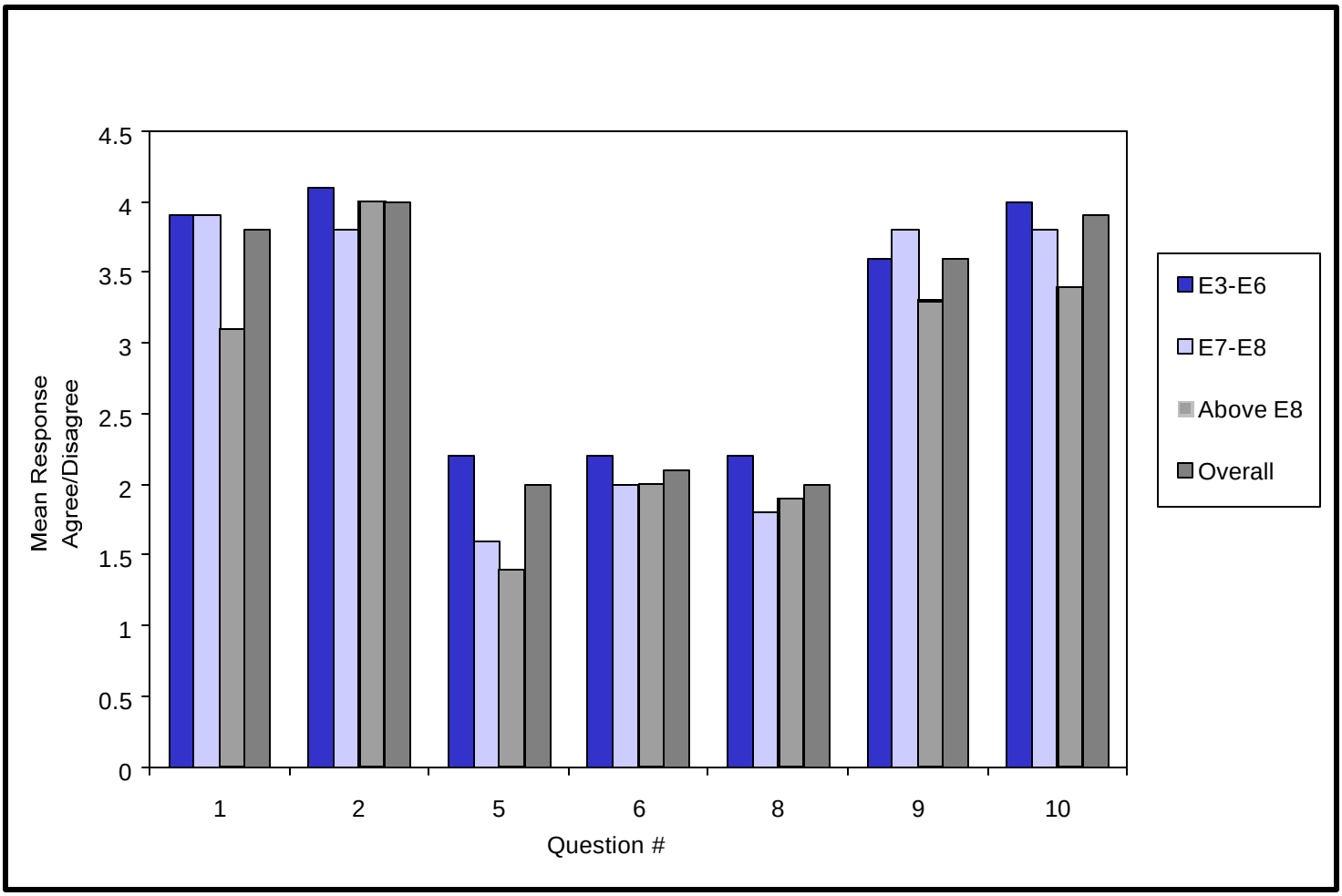
Assistant Editor Ms. N. D. Branch

Prepared by the Navy Environmental Health Center, Preventive Medicine Directorate. Submission and inquiries regarding content or material to be considered for publication should be directed to the Editor, Navy Environmental Health Center, Preventive Medicine Directorate, 2510 Walmer Ave., Norfolk, VA 23513-2617. E-mail morrowr@nehc.med.navy.mil.

To be added to the mailing list, contact the Navy Environmental Health Center at DSN 253-5603, Comm: (757) 462-5603.

In response to the need for training, the Preventive Medicine Directorate at the Navy Environmental Health Center is preparing an on-line tutorial for the program which will be available early in FY00. Finally, there was no consensus among users as to the benefits or primary functions of the program. This is not surprising for an innovation in the early stages of adoption, and as experience with the program develops, a consensus may emerge. Consensus should be reassessed at a later stage of adoption, but this early assessment indicates no strong pre-conceived notions or expectations about the NDRS.

Figure 1. Mean Response by Rank to Selected Questions



GLOBAL SURVEILLANCE OF EMERGING DISEASES

Newly Described Fatal Syndrome in Amazon

Jim Riach
Quito, Ecuador

Editorial Note: The Navy Environmental Health Center continues to contribute to the global emerging infections surveillance (GEIS) effort through development of programs in field informatics, humanitarian assistance, and syndromic surveillance. We recently received the following report of four cases of a fatal syndrome, which are provocative. (These are second hand reports from reliable

sources gathered by a medical anthropologist working in Ecuador, 1999.) We share the case descriptions here to give them the broadest possible dissemination. Please share any diagnostic hypotheses or ideas with the Editor. These cases have little further information available and must be accepted with caution as unconfirmed reports, but the clustering and location make them worth sharing with our readership.

CASE #1

The first case is that of a 25-year-old male who passed away Feb 16, 1999. His symptoms were said to have begun one year before his death while traveling through the Peruvian and Colombian jungles. The initial symptoms were severe pain in the right lower quadrant of the abdomen and severe headache. The abdominal pain persisted and became progressively worse. He also developed pain and weakness in his lower limbs and anemia over a period of a couple of months. He received two blood transfusions and two weeks later (within a few days of the second transfusion) he developed skin lesions on his neck, which resembled gunshot wounds "as if he had been shot from one side to the other". His abdominal pain extended to his chest and back. Within a few days he developed larger lesions on his legs and waist which looked "as though they were rotten". He died a few hours after those lesions developed. His body decomposed at an extremely fast rate, reaching liquification within 48 hrs.

CASE #2

The second case is the 3-year-old daughter of the first patient. Her symptoms also began one year before her death, which occurred a few days after her father's. This patient's initial symptoms included severe headache and body pains. Later her arms, legs, face, and eyes became extremely swollen. She became very pale or white (emphasized very white) and maintained a constant high fever. Her condition did not improve and she subsequently died in a hospital in Quito. The hospital does not have her records. Decomposition rate is unknown.

CASE #3

The third case is of a 10-year-old male. His symptoms were said to have begun 3-4 days before his death around August 1, 1999. Initial symptoms included large bloody blisters of the gums. His developed gunshot-like lesions on his neck and he complained of a burning throat. There was a discharge of yellow fluid from the nose and mouth moments before his death. He died at home and had an accelerated decomposition rate like the first case.

CASE #4

The fourth case is of a 21-year-old male. His initial symptoms, which consisted of a sudden severe headache, began several months before his death on August 27, 1999. The pain persisted until his death. He also suffered dizziness, disorientation "and was not able to speak". He maintained clenched fists and was unable to make purposeful movements with his hand and feet. He was extremely pale. His condition was stable for a while but suddenly worsened rapidly a few days before his death in a hospital in Quito. His body decomposed quite rapidly. This was documented by the treating physician. His was the only post mortem remains that was available for laboratory testing. Samples of blood drawn from this and the first patient prior to their death, were sent for laboratory testing.

Initial testing on the blood samples revealed the presence of antibodies that are thought to be destructive of red blood cells. The documented symptoms of the first three cases could not be obtained since the patients lived outside of the study region.

Discussion: These very interesting cases left the author with many unanswered questions. For example, are these deaths the result of the same disease? If so, what could it be? One suggested hypothesis is that these are all cases of disseminated histoplasmosis (DH). However, none of the patients complained of respiratory problems or had physical findings

suggestive of that. Besides, doesn't the entity DH only occur in AIDS or other patients that are immunocompromised? Finally, what is responsible for the rapid rate of decomposition seen in these patients?

Disclaimer: This surveillance activity was not sponsored or funded by the DoD GEIS activity.

Dengue Hemorrhagic Fever in a Forward-Deployed Clinic

LT Adam L. Hartman, MC, USNR (Staff Pediatrician, USNH Yokosuka)
LTJG Ardath White, MSC, USNR (EHO, NEPMU-2; formerly, DH, Preventive Medicine, USNH Yokosuka)

Case.

An 8 year old female presented to the Pediatric Clinic at US Naval Hospital Yokosuka with a fever of 103.8^{o}F one day after immigrating to Japan from Thailand. Her home was in a village located approximately 120 km south of Bangkok. It was during the rainy season but her mother did not notice any insect bites; there were no other known contacts with animals or ticks. She was evaluated at a clinic near her village for fever, headache, and sore throat three days prior to her evaluation in our clinic. She had received multiple courses of unknown medicines in Thailand at various clinics. At our clinic, she had a mild headache and fever. She did not have respiratory, gastrointestinal, rheumatological, or dermatological symptoms, nor was there abdominal/back pain or dysuria. Her immunization status was unknown. There was no significant past medical history. She looked ill but not toxic. Her exam was remarkable for a temperature that climbed to 104.7^{o}F in the clinic, dry mucous membranes, minimal exudate on the left tonsillar pillar, and a 1-cm anterior cervical lymphadenopathy. Her neck was supple. Her abdomen was diffusely tender but no organomegaly was appreciated. The remainder of her exam was unremarkable. Her lab studies were remarkable for a low white blood cell count and low platelets. Her muscle enzymes were elevated, indicating inflammation of the muscle itself. After an initial fluid bolus, her clinical appearance improved. Three hours after being dehydrated, her albumin decreased (indicating some capillary leak). A monospot was negative. Thin and thick blood smears for malaria were negative. Radiographs of her chest and abdomen were normal. She was initially hospitalized in our hospital for hydration and observation. She was normothermic. Six hours after admission, her white blood cell count increased to normal but her platelets were still low. Her clotting parameters were abnormal (PTT and d-dimer). Oozing was noted from her phlebotomy sites. Experts from the Navy Environmental Health Center (VA), Uniformed Services University of the Health Sciences (MD), Centers for Disease Control and Prevention (PR), Tripler Army Medical Center (HI), and Navy Environmental and Preventive Medicine Unit-6 (HI) were consulted during the admission. The GIDEON (Global Infectious Disease and Epidemiology Network) computer program was used to help generate an infectious differential diagnosis. Due to the fact that a bleeding problem and a possible oncological (cancerous) process were evolving, the patient was transferred to a local Japanese hospital. Her laboratory studies there were initially abnormal but the bleeding problem resolved on its own. A bone marrow biopsy was normal. She was transferred back to our hospital two days later. Her general clinical appearance had dramatically improved. An EKG and echocardiogram were normal. A number of laboratory studies from her initial hospitalization were normal except for a throat culture that showed rare *S. pyogenes*. Tests for Hepatitis A and B, Dengue IgM, leptospirosis, lupus, and HIV I & II were negative, as was an RPR. Dengue IgM and IgG titers were positive one month after her initial presentation to our clinic. Further consultation with US Navy Medical Research Unit 2 (Jakarta, Indonesia) and the US Armed Forces Research Institute of Medical Sciences

(Bangkok, Thailand) was obtained for a final analysis of the results. The final diagnosis was acute secondary dengue infection (with hemorrhagic manifestations).

Discussion. This case highlights a number of critical issues to those practicing in a forward-deployed environment.

Communication with experts was one of the keys to the evaluation of this patient. Experts in CONUS were consulted via a variety of media – telephones, the Internet, and regular mail. New computer technology was also available at USUHS. A wide spectrum of expertise was used to evaluate this patient, including pediatric and adult infectious disease, preventive medicine, epidemiology, microbiology (including virology), and pediatric oncology. Knowledge of the available resources can be key to making the correct diagnosis and avoiding unnecessary tests while ensuring safety of the general public.

The importance of discussing travel histories and animal/ insect contacts with patients cannot be overemphasized. In this case, the overwhelming suspicion of dengue infection based on geographic considerations was the key to making the correct diagnosis. This was particularly relevant since the computer-generated diagnosis did not rank dengue infection high on the list of differential diagnoses.

Finally, the presence of an extensive travel history does not exclude the possibility of other processes, most commonly, oncological (cancerous), toxic, or rheumatological. One of the most common errors in diagnosis is narrowing the differential diagnosis too early in the patient's evaluation.

HEALTH PROMOTION

Navy Environmental Health Center Launches Sexual Health and Responsibility Program

Bill Calvert, MS, MBA, MPH
Navy Environmental Health Center, Norfolk, VA

The Sexual Health and Responsibility Program (SHARP) is an element of the Health Promotion and Medical Management Directorate of the Navy Environmental Health Center (NEHC) located in Norfolk, Virginia. SHARP began full operation in the second quarter of fiscal year 1999. The program was developed as part of the transfer of the Navy's HIV Education Program from NNMC Bethesda to NEHC.

SHARP Goal

Reduce the occurrence of HIV, Sexually Transmitted Disease (STDs) and other unplanned consequences associated with the sexual behavior of military members and other DoD beneficiaries

SHARP Objectives

- Provide information and education programs on the prevention of HIV-STDs.
- Implement programs that promote positive behavior changes and responsible decision-making regarding human sexuality.
- Design programs targeting those persons whose behavior puts them at high risk of infection, such as patients in STD clinics, persons referred to drug and alcohol treatment programs, and family planning clinic patients. Provide programs for health-care personnel to assess patients' understanding and risk behaviors and effectively communicate this information to patients.

USN and USMC HIV-STD Education Requirement:

HIV instruction for active duty Navy and Marine Corps personnel is required annually. Other groups identified at increased risk of exposure to HIV and other STDs will receive additional focused counseling by appropriate professionals. HIV instruction will also be available to civilian employees (SECNAV NOTICE 5300; SECNAVINST 5300.30C; USMC MCO 6200.4A)

SHARP Roles

Commanders and Agency Heads

- Provide annual, one-hour HIV education to all hands, (including new civilians during orientation) as required by SECNAV NOTICE 5300.
- Provide additional HIV-STD education to other groups identified at increased risk of exposure to HIV and other sexually transmitted diseases (STD as required by SECNAVINST 5300.30C and USMC MCO 6200.4A.

NEHC SHARP Program Manager

- Provides education programs to increase HIV-STD prevention, knowledge and skills, and promote behavior changes that reduce the risk of exposure.
- Administers the Navy HIV Instructor Course (on-line, self-study).
- Promotes development of appropriate training materials.
- Notifies Area Coordinators of newly registered HIV instructors within their area who successfully complete the Navy HIV Instructor Course.
- Keeps instructors informed of epidemiological, medical, and administrative changes.
- Coordinates with research, administrative, and policy making bodies on HIV issues
- Reports on the status of HIV/STD education to Headquarters and the Joint Staff STD Prevention Committee.

Area Coordinators (AC)

HIV Education Area Coordinators are needed as the SHARP program continues to revitalize the program of HIV-STD prevention education. More than half the areas worldwide have identified key personnel to champion the effort. Area Coordinators:

- Support HIV trainers within their Area.
- Receive and distribute training materials from NEHC to HIV Trainers.
- Maintain rosters of current HIV Instructors and Instructor-Trainers (IT) within their Area.
- Coordinate training requests between commands and available instructors as needed, e.g., providing instructor names.
- Report the number of classes conducted and participants attending these classes to the NEHC SHARP Director on a quarterly basis.
- Assist with certification of instructors as IT.

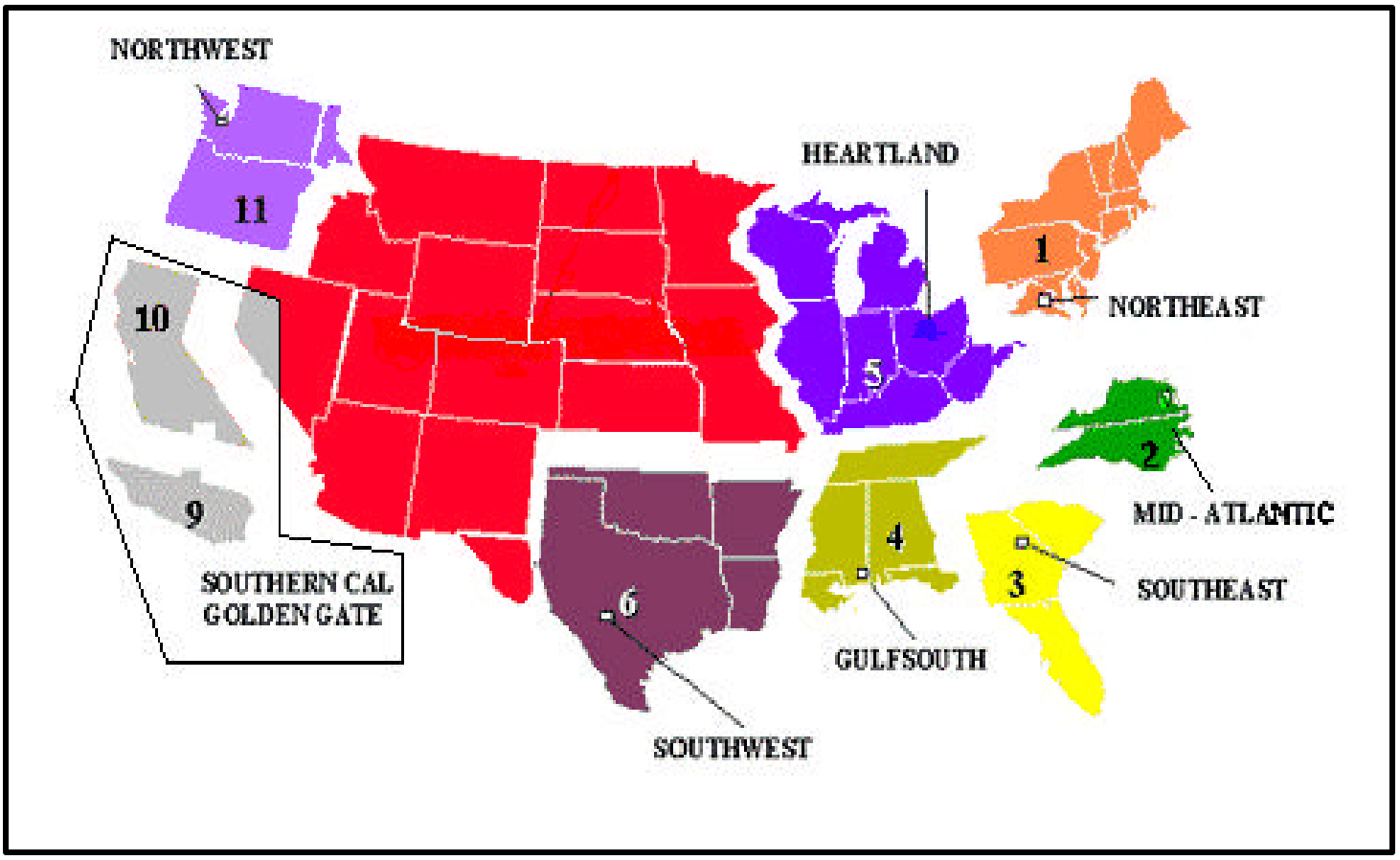
Instructors

- Use factual information about HIV/STD to increase personal skills and promote behavior changes that decrease risks.
- Report workload data to their AC after each class.

SHARP "Areas"

SHARP Areas approximate Tricare Regions as depicted in Figure 1. There is one SHARP Area Coordinator designated in each Area.

Figure 1. Designated SHARP Locations



Area & Area Name

1 Northeast
2 Mid-Atlantic
3 Southeast
4 GulfSouth
5 Heartland
6 Southwest
9-10 Southern Cal -Golden gate
11 Northwest
12 Hawaii*
13 Pacific*
14 Latin America*
15 Europe*

For more information about SHARP, contact:
Navy Environmental Health Center
Health Promotion and Medical Management
SHARP 2510 Walmer Ave Norfolk VA 23513-2617 http://www-nehc.med.navy.mil/hp voice: (757) 462-5566 {DSN 253} fax: (757) 444-1345 {DSN 544}

COMMUNICABLE DISEASES

BUMED HIV Screening Program Update

CDR P. E. Amato, MC, USNR
CDR W. Z. McBride, MC, USN
MED-24B, Washington, D.C.

Issue: The HIV epidemic continues to be an important infectious disease problem of global proportions affecting the general population as well as the US Military. Since 1985, the DON has conducted an HIV screening program for active duty, reserve members and all new assessions. This report summarizes the present policy and trends in testing results with a comparison to the general population data.

Navy Policy:

Guidance: DOD Directive 6485.1(19 Mar 91) and SECNAVINST 5300.30^{c} (14 Mar 90).
Testing: Screening test run by contractor, ViroMed Labs, Inc. Minneapolis from 7/95 to present. Cost ~ $3 per test including confirmation of all positives.
Testing Policy: (USN & USMC) Annual testing required for deployed, oversea units, health care providers and US based deployable units (must have valid test within last 12 months). All others tested at regular physical examinations (Q 5 years to age 50; Q 2 years > 50). All new assessions screened by MEPS or N/MC officer entry programs through an MTF. HIV + individuals are ineligible for entry. Reservists are tested annually and must have a valid test within 12 months prior to any AT or deployment.
HIV positive members: HIV+ members may remain on active duty but must be stationed within 300 miles of 17 MTFs (limited to the US, including PR, Alaska, & Hawaii). They are reevaluated twice per year and processed through disability retirement system when medical condition deteriorates. All evaluations done at NNMC Bethesda, NMC Portsmouth and San Diego. Member found unfit generally when CD4 lymphocytes count < 300 with partial loss of skin testing reactivity to common antigens or when clinically appropriate. Likewise, Naval reservists may remain active but are limited as to the site of acceptable AT and are not deployable, i.e., they follow similar limitations as their active duty counterparts.

Screening Results:

Accompanying tables (1-4) and figures (1-4) summarize data. The key points are listed below:

- USN sero-conversion rates have decreased significantly over the last decade.
- USN rates are now similar if not lower than the general public.
- USN rates are now the lowest of the Tri-services (USN, USA, USAF).
- DON (USN & USMC) has the highest percent of force tested annually of the Tri-service armed forces.
- There still remains a significant disparity between racial/ethnic groups in HIV Sero-conversion rates in DON as well as the general US population. African Americans show the highest racial/ethnic group rate. FY conversion rates in DON as well as the general US population. African Americans show the highest racial/ethnic group rate. FY 1998 sero-conversion was 0.53 for African Americans vs 0.10 for whites in USN (HIV+ individuals per 1000 persons tested).
- Most new sero-conversions are among enlisted African Americans. CDC general population data show African/Americans to have a significantly higher prevalence as well as a higher incidence. As of 30 September 1998 there were 417 HIV+ members on active duty at DON. The US/Army has 295 HIV + individuals on active duty as of 30 June 1999.

(cont. on page 10)

SUMMARY OF 1999 DATA AS OF AUGUST 1999

Table 1. Reportable Diseases, Combined Navy & Marine Corps Active Duty Case Frequencies, 1999			
Disease	**Total**	**Disease**	**Total**
Amebiasis	0	Measles	0
Anthrax	0	Meningitis (viral)	0
Bites, Non-venomous rabies vax given	0	Meningococcal disease	2
Bites, Venomous	6	Mumps	0
Brucellosis	0	Onchocerciasis	0
Campylobacter	1	Paratyphoid Fever	0
Chancroid	0	Pertussis	0
Chlamydia	20	Plague	0
Coccidioidomycosis	0	Poliomyelitis	0
Cryptosporidiosis	0	Psittacosis	0
Dengue Fever	0	Q Fever	0
Diphtheria	0	Rabies Human	0
E. coli 0157:H7 Infection	0	Relapsing Fever	0
Encephalitis	0	Rheumatic Fever	0
Ehrlichiosis	0	Rift Valley Fever	0
Filariasis	0	RMSF	0
Giardiasis	0	Rubella	0
Gonorrhea	76	Salmonellosis	0
Gullian-Barre Syndrome	0	Schistosomiasis	6
Hantavirus Infection	0	Shigellosis	0
Hepatitis A	0	Smallpox	1
Hepatitis B	0	Strep, Invasive	0
Hepatitis C	3	Syphilis	4
H. Influenzae, Invasive	1	Tetanus	0
HIV, Occupational exposure	0	Toxic Shock Syndrome	0
Influenza (outbreak only)	1	Toxoplasmosis	0
Lassa Fever	0	Trichinosis	0
Legionellosis	1	Trypanosomiasis	0
Leishmaniasis	0	Tuberculosis (Pulmonary)	0
Leprosy (Hansen's Disease)	0	Tularemia	7
Leptospirosis	0	Typhoid Fever	0
Listeriosis	0	Typhus	0
Lyme Disease	0	Varicella	7
Lymphogranuloma Venereum	0	Yellow Fever	0
Malaria	0		

Comments:

Navy and Marine Corps sites are making the transition to an electronic monthly reporting system. We have received data from the four NEPMUs since their submission of the 1998 yearly report (published in NMSR Vol. 2, No 2, Apr-Jun, 1999). 1998 is the last year in which annual reports will be submitted. BUMEDINST 6220.12A mandates that medical events reports (MERs) be sent monthly to the regional NEPMU and then to NEHC. Table 1 shows the distribution of cases reported since the 1998 year-end reports. These data represent approximately half a year's reporting from all four NEPMUs but not necessarily from all reporting sites, as some may still be on the former schedule of preparing year-end reports.

There have been only 73 reports submitted on non-active beneficiaries so far in 1999 and we feel this number is too small to present by subset.

(continued from page 8)

- USAF data of HIV+ individuals on active duty and gender analysis were not available for this report.

Conclusions:

- The DON's screening program is effective in identifying HIV+ individuals. Early identification allows the member to be aggressively treated. Per the CDC, education, prevention and aggressive combined treatment will result in a reduction in the rate of rise of AIDS cases as well as an increase in the life expectancy of HIV+ individuals.
- Per the CDC, the prevalence of HIV+ individuals will continue to rise. The rate of increase of HIV+ and AIDS cases has slowed.
- The DON can anticipate a constant but slow rise in HIV+ individuals, with a corresponding increase in the number eligible to remain on active duty.
- The rate of sero-conversion of Navy members is now equal or lower than the general population, down from significantly higher rates seen in previous years. Prevention/ education programs should be continued to ensure these rates remain low.

Table 1. INCIDENCE OF HIV SEROCONVERSION 1994-1998

ACTIVE DUTY US NAVY				
Year	**Number HIV Seroconverters**	**Number Tested**	**Incidence Rate Per 1000**	**% of Force Tested**
1994	118	388255	0.30	82
1995	87	384573	0.23	90
1996	94	357477	0.26	88
1997	61	363779	0.26	94
1998	58	342431	0.27	92

Table 2. INCIDENCE OF HIV SEROCONVERSION 1994-1998

ACTIVE DUTY US MARINE CORPS				
Year	**Number HIV Seroconverters**	**Number Tested**	**Incidence Rate Per 1000**	**% of Force Tested**
1994	28	161539	0.17	91
1995	18	167662	0.11	96
1996	22	160239	0.14	92
1997	22	168892	0.13	97
1998	13	173200	0.08	100

Table 3. INCIDENCE OF HIV SEROCONVERSION 1994-1998

DEPARTMENT OF THE NAVY				
Year	Number HIV Seroconverters	Number Tested	Incidence Rate Per 1000	% of Force Tested
1994	146	549794	0.27	85
1995	105	552235	0.19	92
1996	116	517716	0.22	89
1997	83	532671	0.14	95
1998	71	515631	0.14	95

Figure 1. HIV Seroconversion Rates by Service, Department of Defense 1990-1998

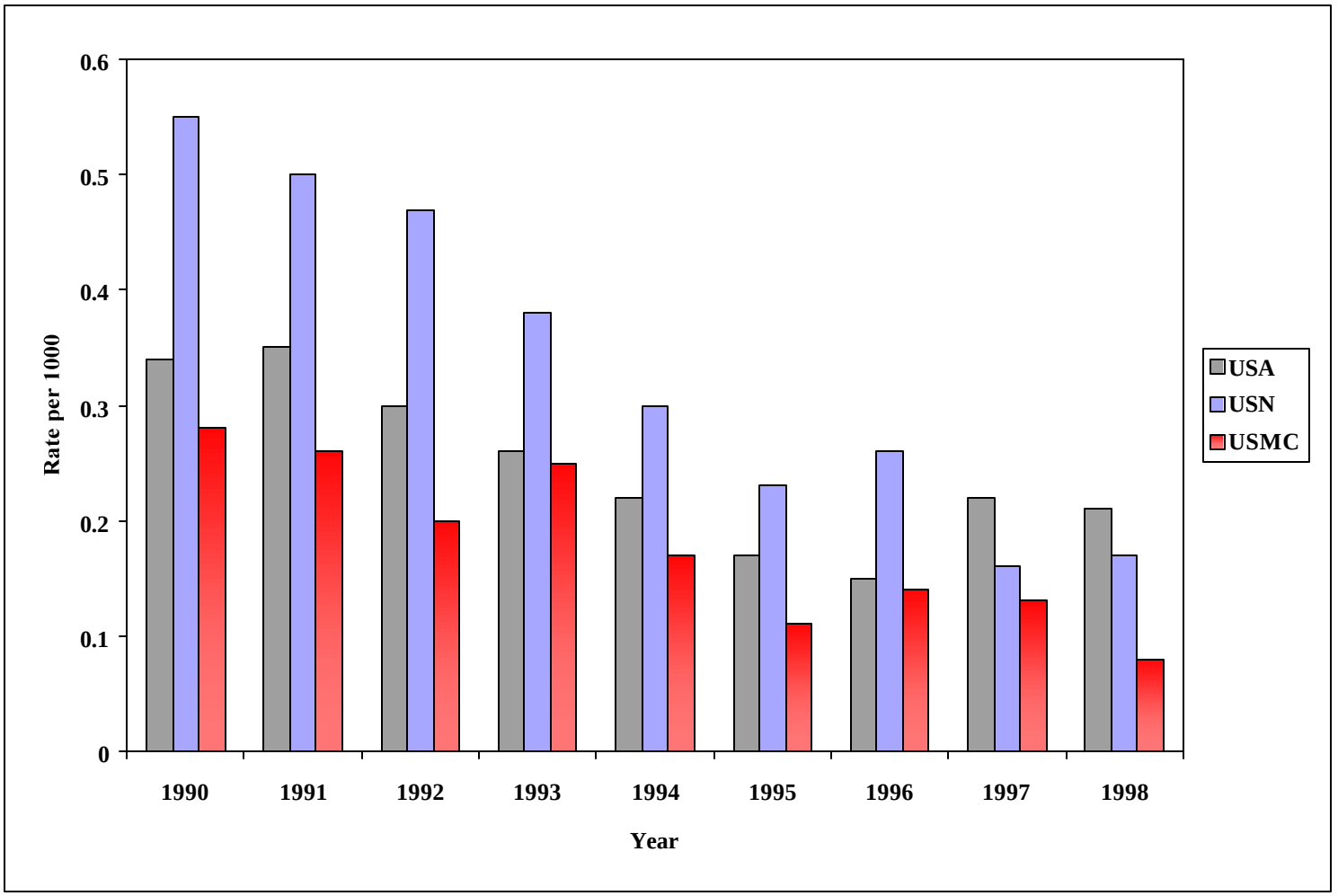


Figure 2. HIV Seroconversion Rates by Gender, USN and USMC 1990-1998

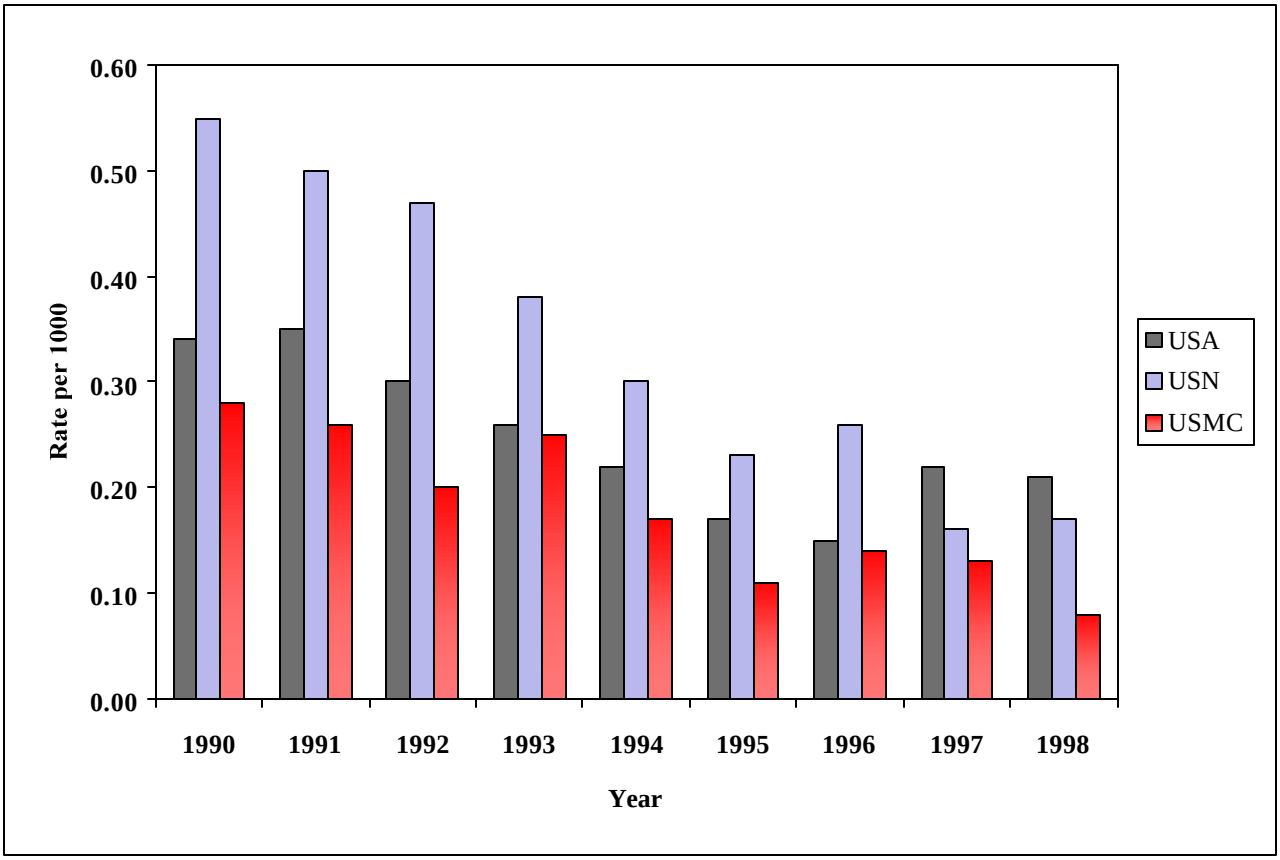


Figure 3. HIV Seroconversion Rates for USA, USN, and USMC Men, 1990-1998

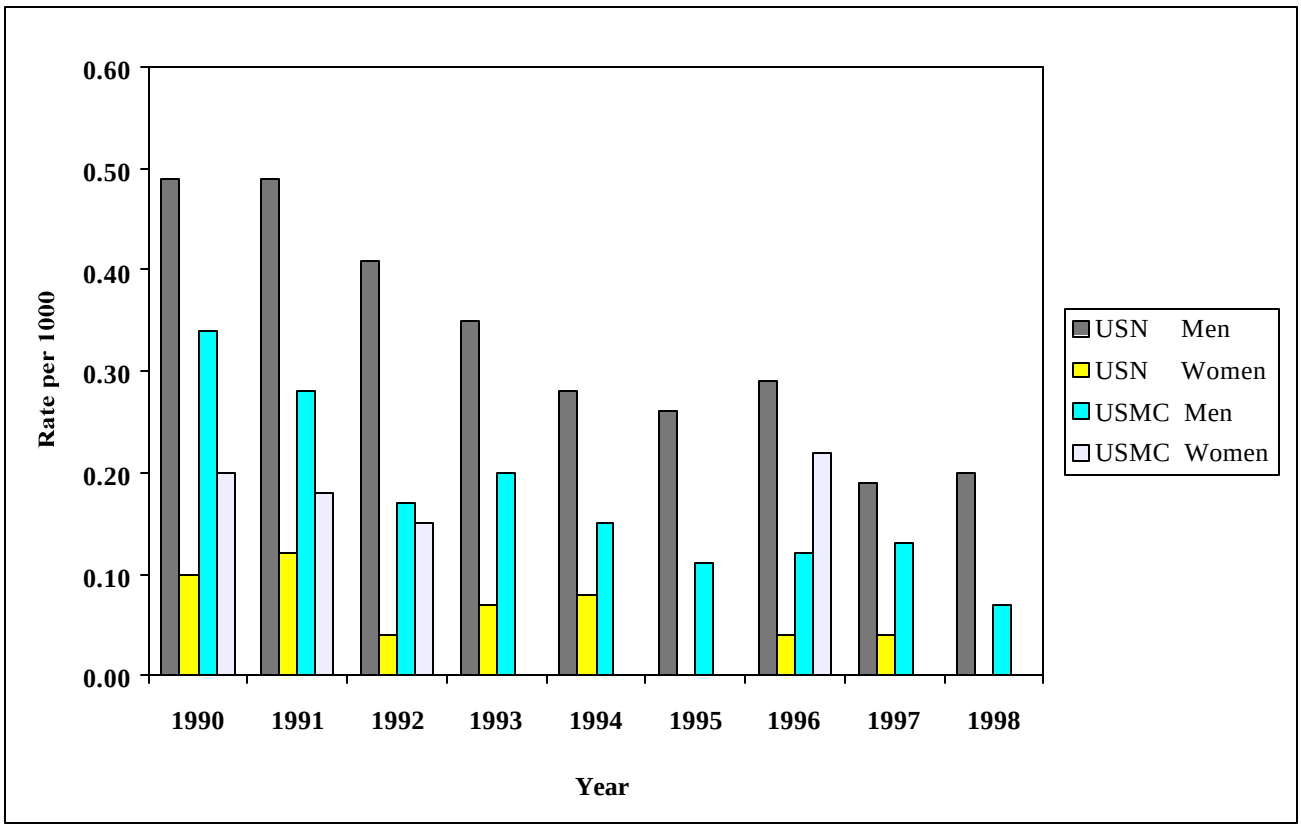
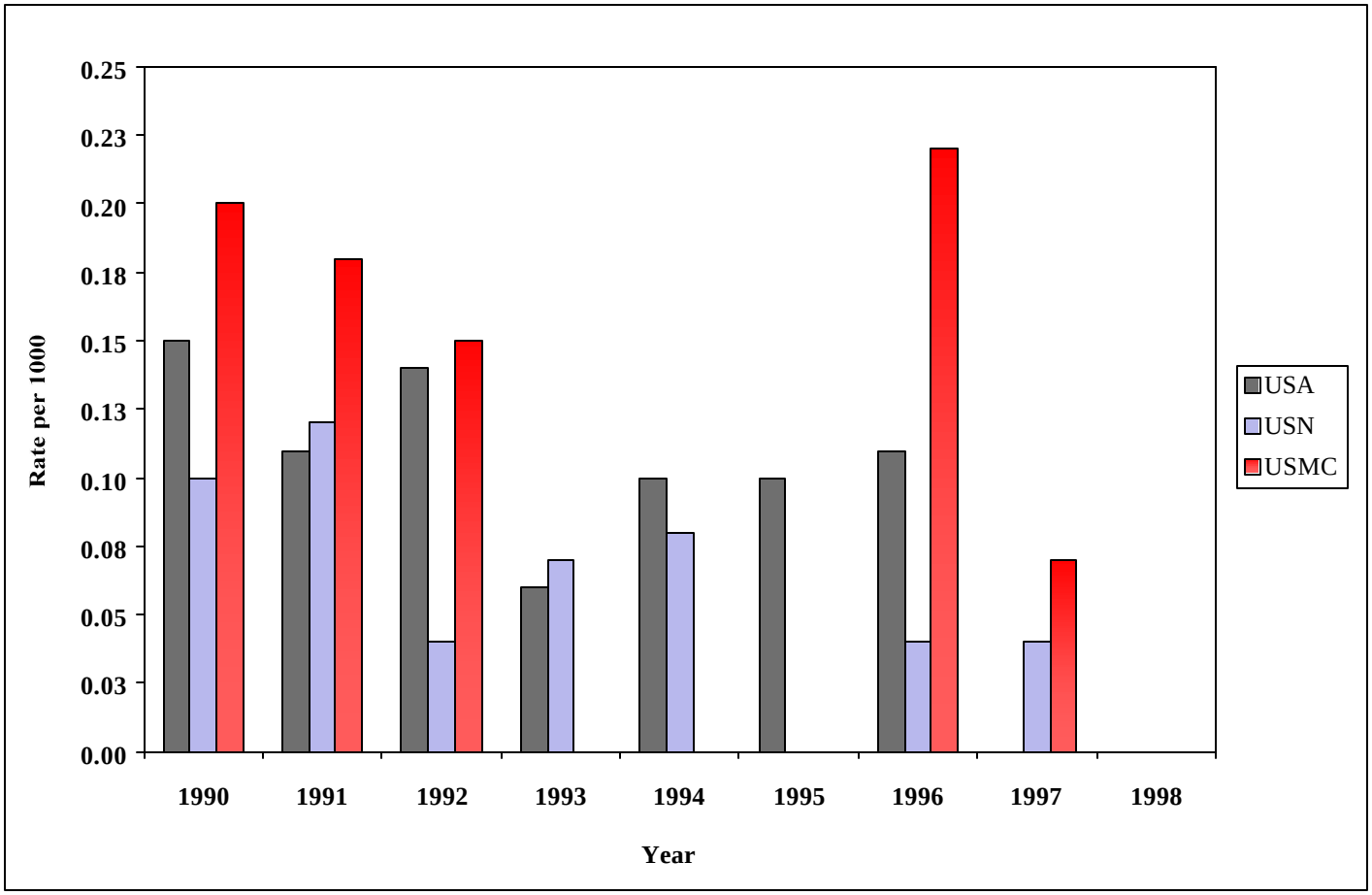


Figure 4. HIV Seroconversion Rates for USA, USN, and USMC Women, 1997-1998*



* Data for USA not available for 1997&1998; Rates for USN & USMC are zero for 1998

Table 4. AIDS/HIV Incidence Rates/1000 for Tri-Services & General US Population Comparison of US Navy and General US Population HIV/AIDS Rates

Year	US HIV[1] Incidence	US AIDS Rate[2]	US Military Recruits[o]	DON[3]	USN[3]	US Army[3]	USAF*
1997	**~0.26-0.36**	**0.211**	**~0.4**	**0.14**	**0.16**	**0.22**	**0.24**
1998	**N/A**	**0.176**	**N/A**	**0.14**	**0.17**	**0.22**	**0.20**

[o] No. of cases per 1000 applicants (similar to prevalence not incidence).

[1] Estimate by CDC (no. per 1000 persons). Source: CDC- National HIV Surveillance Report 1997.

[2] US rate of newly reported AIDS cases (no. per 1000 population). This number is not HIV positive clinically asymptomatic cases. Source: CDC NCHSTP - HIV/AIDS Surveillance Report –1998.

[3] Rate of new positive HIV cases (no. per 1000 people tested). Source: CDC-NCHSTP-DHAP - National HIV Prevalence Survey- 1997 Summary

* US Air Force Incidence is Rate per 1000 tests.

NMSR Publication Information for Contributors

NMSR publishes articles that report on the health of US Naval forces. The Report seeks to advance our understanding of the various health issues of our forces by providing a forum for the exchange of information and ideas that are relevant to promoting health and preventing disease among our communities. Articles are invited in the following categories:

(1) Disease Medical Surveillance
(2) Naval Disease Reporting System/Disease Non-Battle Injury (NDRS/DNBI)
(3) Disease Outbreaks
(4) Infectious and Chronic Diseases
(5) Injury and Health Promotion
(6) Global Emerging Infections Surveillance

The Report, at the discretion of the editors, will also publish:

(1) editorials,
(2) commentaries,
(3) articles concerning emerging technology,
(4) information (news) and events.

Hard Copy Submission

Send the original manuscript, including illustrations and/or figures to the editor, NMSR Navy Environmental Health Center, Preventive Medicine Directorate, 2510 Walmer Avenue, Norfolk, VA 23513 USA. Deadline date of submission is the 15th of the mid month of the quarter.

Electronic Submission

Submit electronically prepared manuscripts on 3.5-inch diskettes as either a Microsoft Word or WordPerfect document to morrowr@nehc.med.navy.mil. Submit tables, graphs and figures as separate files. Include mailing address, telephone and fax numbers of corresponding author. Indicate the software used. Deadline date of submission is the 15th of the mid month of the quarter.

Format for Manuscripts

Prepare articles in accordance with the American Medical Association Manual of Style or the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (1&2).

- Use only standard 10 or 12-point font size, double-spaced throughout
- Articles should be graphically oriented, with text limited to 600 words and must not exceed 3 pages, including references, tables, and figures.
- Do not include a running header or footer, and put the authors' names only on the title page.
- Be concise and avoid medical jargon.
- Do not use acronyms or abbreviations in the title or abstract. Keep abbreviations and acronyms within the text to a minimum and spelled out, in parentheses, when first used.

Title page

Should contain the following information:

(1) title of article;
(2) full name(s) of author(s);
(3) military rank or highest academic degree(s);
(4) locations(s) by city, state, country;
(5) name and address to which correspondence and reprint requests should be sent;
(6) the date on which the manuscript was submitted;
(7) a word count for the text, exclusive of the title, abstract, references, tables, figures and illustrations

Abstract

Abstracts (when applicable) should not exceed 200 words and should not include abbreviations, footnotes, trade names, or references. For research

manuscripts and case reports use the format:

(1) Background and Objectives,
(2) Methods,
(3) Results, and
(4) Conclusions [or Discussion].

For review articles use the format:

(1) Background,
(2) Data Base, and
(3) Conclusions [or Discussion].

Text

For research articles, follow this format:

(1) Introduction,
(2) Materials and Methods,
(3) Results,
(4) Discussion, and
(5) Conclusions.

Acknowledgements

Acknowledge only those who made significant contribution to the work.

References

Authors are responsible for bibliographic accuracy. References must be verified by the author against the original resources. Number the references in the order they are first mentioned. Use no more than 5 references. Review articles may use up to 10 references. Double-space the references and use the format recommended in the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals."

Examples of Reference Style:

Journal Reference

1. Berg C, Atrash H, Koonin L, et al. Pregnancy-related mortality in the United States, 1987-1990. Obstetrics and Gynecology 1996; 161-7.

Book Reference

2. Zinsser W. On Writing Well. 4th ed. New York, NY: Harper Collins; 1990.

List all journal authors when 6 or fewer. For journal references with 7 or more authors, list the first 3 and add "et al." Manuscripts submitted, but not yet accepted for publication, can be noted as "unpublished data" in the text. However, do not include in the references any manuscripts that are in preparation, manuscripts submitted for publication but not yet accepted, or unpublished papers or observations. For articles in press, give the journal name and, if possible, the volume number and year followed by "in press." For books in press, give the publishing company and, if possible, the year of publication.

Tables

Tables should be concise and sufficiently self-explanatory so that readers can understand them without reference to the text. They should not duplicate material presented in the text. Tables should be titled, cited in the text, and numbered consecutively with Arabic numerals, in order of appearance.

Figures and Illustrations

Submit an original and 3 sets of each figure or illustration (e.g. photographs, charts, graphs). Number them according to their order in the text.

Legends

Legends of no more that 15 words each should be typed, double-spaced, on separate pages and identified by sequential number which illustration of figure they are meant for.

Cover Letter

The author responsible for correspondence must include a cover letter that certifies that:

(1) the manuscript submitted has been seen and approved by all authors,

(2) Chain of command authorization has been obtained, when appropriate.

Author(s) Information

A separate page must be submitted containing the names, addresses, telephone numbers, fax numbers and e-mail addresses for all authors for the manuscript. Clearly indicate who is the corresponding author.

Letters to the Editor

The editor invites brief letters that comment on articles published in the report. The letters should not exceed 300 words in length, and contain no figures or tables. Up to three references may be listed. The letter must identify the article by naming the authors and title of the article in the text of the letter. No letter will be published more than 6 months after the publication of the article to which it refers.

Submission Checklist:

- Cover letter
- 3.5-inch diskette containing the prepared manuscript saved as a Microsoft WordPerfect document.
- Authors' Information.
- Original and 3 copies of double spaced manuscript, including: tables, figures, and illustrations.

Elements of the manuscript include:

(1) title page
(2) abstract
(3) text
(4) acknowledgments
(5) statement of disclosure
(6) references

Editorial Process and Policy

The selection of submitted articles for publication is made by the editors. All materials accepted for publication are copy-edited and those with significant recommended editorial changes are returned to the author for approval. The editors reserve the right to make minor changes for clarity and accuracy without seeking author approval

REFERENCES

1. Iverson CL, Flanagin A, Fontanarosa PB, et al. American Medical Association Manual of Style: A Guide for Authors and Editors 9th ed. Baltimore, MD: Williams & Wilkins; 1998.

2. International Committee of Medical Journal Editors. Uniform Requirements for Manuscripts Submitted to Biomedical Journals. JAMA. 1997 277:927-934

DEPARTMENT OF THE NAVY
Commanding Officer
Navy Environmental Health Center
2510 Walmer Avenue
Norfolk, VA 23513-2617

Official Business